

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 4-14-03.

### I. DISPUTE

Whether there should be reimbursement for CPT code 23466-80.

### II. FINDINGS

The respondent denied reimbursement based upon "F – Documentation does not meet the criteria for use of this CPT code."

### III. RATIONALE

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
4-24-02	23466-80	\$1000.00	\$0.00	F	\$2023.00 X50% = \$1011.50 X 25% = \$252.88		CPT code 23466 is defined as "Capsulorrhaphy with any type multi-directional instability." A review of the operative report supports service, reimbursement of \$252.88 is recommended.

### IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT code (23466-80) in the amount of **\$252.88**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$252.88** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 12<sup>th</sup> day of January 2005.

Medical Dispute Resolution Officer  
Medical Review Division